Utah Department of Health
Bureau of Health Facility Licensing, Certification and Resident Assessment

State of Utah Health Care Facility Rule R432-031
Physician Order for Life Sustaining Treatment
(http://health.utah.gov/hflcra/forms.php)

Physician Order For Life Sustaining Treatment This is a physician order sheet based on patient/resident wishes and medical indications for life-sustaining treatment. If this is in the clinical record, this should be placed in a prominently visible part of the patient's record. When need occurs, first follow these orders, then contact the physician	Last Name of Patient/Resident: First Name/Middle Initial: Date of Birth:

(ANY SECTION NOT COMPLETED INDICATES ALL TREATMENT IN THAT SECTION WILL BE PROVIDED)

Section A Check one	**Treatment options** when the patient/resident **has no pulse and is not breathing** ___ Resuscitate ____ Do not attempt or continue any resuscitation (DNR)
Section B Check one	**Treatment options** when the patient/resident **has pulse and is breathing**. __Comfort measures only: Oral and body hygiene, reasonable efforts to offer food and fluids orally, medication, oxygen, positioning, warmth, and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient/resident. Other instructions: Transfer only if comfort measures can no longer be effectively managed at current setting. Transfer only if necessary to: _____ __ Limited additional interventions: Includes care above. May also include suction, treatment of airway obstruction, bag-mask/demand valve, monitor cardiac rhythm, medications, IV fluids. Transfer to hospital if indicated, but no endotracheal intubation or long-term life support measures. Other instructions, specify: _____ ___ Full treatment: Includes all cares above plus endotracheal intubation and cardioversion.
Section C Check all that apply	**Antibiotics:** Comfort measures are always provided. ___ No antibiotics, except if needed for comfort ___ Oral antibiotics ___ Intravenous antibiotics ___ Intramuscular antibiotics Other Instructions:
Section D Check all that apply	Artificially administered fluid and nutrition: **Feeding Tube**: ___ No feeding tube ___ Defined trial period of feeding tube ___ Long-term feeding tube **IV Fluids**: ___ No IV fluids ___ Defined trial period of IV fluids ___ IV Fluids Other Instructions:
Section E Check all that apply	Discussed with ___ Patient/Resident ___ Legal Representative ___ Other, (specify): _____ Contact name and phone number:

A COPY OF THIS FORM MUST ACCOMPANY PATIENT/RESIDENT ON TRANSFER OR DISCHARGE (INCLUDING TRANSFERS TO HOSPITAL EMERGENCY DEPARTMENTS)

Patient/Resident preferences as a guide for physician order for life-sustaining treatment

Section F	I have given significant thought to life sustaining treatment. The following have further information regarding my preferences: Advance Directive ___ no ___ yes Living Will ___ no __ yes Medical Treatment Plan ___ no ___ yes Court-appointed guardian ___ no ___ yes Power of attorney for health care ___ no ___ yes I expressed my preferences to my physician and/or health care provider(s) and agreed with the treatment order on this document. Please review these orders if there is a substantial permanent change in my health status, such as: Close to death Advance progressive illness Improved condition Permanently unconscious Extraordinary suffering Surgical procedures

Brief summary of medical condition:		
Signature of person preparing form (e.g., nurse or social worker)	Print name and phone number:	Date and time prepared
Signature of Physician or other Licensed Practitioner	Print Name: License number and phone number:	Date and time prepared
Patient/Resident Signature/Legal Representative (when possible)	Print name and phone number	Date and time signed

How to Change "Physician Order For Life Sustaining Treatment (POLST)"

This form, Physician Order For Life Sustaining Treatment, should be reviewed if:

1. The patient/resident is transferred from one care setting to another;
2. There is substantial permanent change in patient's/resident's health status; or
3. The patient/resident treatment preferences change.

Review Patient/Resident Preferences as a guide for Physician Order for Life Sustaining Treatment (Section F). Record the review in Review of Physician Order For Life Sustaining Treatment (Section G). To void this form, a physician draws a line through the Physician's Order and/or writes "VOID". Sign and date the form. If no form is completed full treatment may be provided.

Section G	**Review of Physician Order For Life Sustaining Treatment**		
Date of Review	Reviewer	Location of Review (e.g., hospital, NF, HH, clinic)	Outcome of Review
			___ No change ___ Form voided, no new form ___ Form voided, new form ___ Change reflected on form
			___ No change ___ Form voided, no new form ___ Form voided, new form ___ Change reflected on form
			___ No change ___ Form voided, no new form ___ Form voided, new form ___ Change reflected on form